April 8, 2022

JAIME PEREZ
74 MERYL COURT
GROTON CT 06340

RE: Jaime Perez
Paid Leave Benefit Case ID: 00353299

Notification of Application

Reason:	Your Injury or Illness
Type:	Continuous
Date of Leave:	April 10, 2022
Requested Time:	April 10, 2022 - May 5, 2022

Thank you for contacting Aflac. We will be administering your application for benefits on behalf of CT Paid Leave program. This letter confirms your paid leave benefit case has been set up and outlines the next steps. The letter is not an approval of your application.

If any of the above information is incorrect or has changed, or if you have questions, please contact us right away.

Next Steps:

To process your application, we must verify that you are eligible for paid leave benefits and review documentation that demonstrates that the reason you applied for benefits is covered by the CT Paid Leave program. We also need information from your employer relating to your employment and absences from work.

Documentation You Must Provide in Order to Pursue Your Claim for Benefits:

We need you to provide the information we're asking for by **April 25, 2022**.

If incomplete information is provided or we receive it late, your benefits may be delayed or denied. We have enclosed a checklist to help you organize and stay on track with the information you need to provide us.

Authorization for Release of Health Related Information
We need you to complete and sign the Authorization for Release of Health Related Information. This will give us permission to work with your provider to obtain information on your behalf to support your paid leave benefit claim. We have included the form for you to complete or you can visit https://

ctpaidleave.org/ and register/login; and electronically sign the Authorization for Release of Health Related Information.

We need you to provide us with a Certification for Serious Health Condition form completed by your health care provider.

We need your employer(s) to complete the enclosed Employment Verification form to provide us with additional information we could not obtain during your claim intake.

We need you to provide documentation that will enable us to verify your identity and protect you from identity theft. Please submit one stand-alone document OR two alternate documents. **Do not send original documents.**

Stand-alone documents

The easiest way to provide proof of identity is a color copy of your Connecticut driver's license or ID. If you don't have a Connecticut driver's license or ID, you will need to provide **ONE** of the following documents for ID proofing:

- **Valid** United States government (federal or state) issued form of identification (i.e., passport, passport card, ID card, enhanced or standard driver's license)
- **Valid** United States Citizenship and Immigration Service ID
  Form I-766 Employment Authorization
  Form I-551 Permanent Resident Card
- **Valid** foreign government issued form of identification (i.e., passport, consular ID card, national identification card)

Alternate documents

Please provide **one** of the documents from Column A and **one** of the documents from Column B.

Column A	Column B
☐ A certified copy of your birth certificate filed with a State Office of Vital Statistics or equivalent agency in your state of birth	☐ An SSN Card ☐ A W-2 Form
☐ A certificate of Citizenship, Form N-560, or Form N-561, issued by DHS	☐ An SSA-1099 Form ☐ A Non-SSA-1099 Form
☐ A certificate of Naturalization (Form N-550 or N-570)	☐ A pay stub with your full name and SSN on it ☐ An authorization letter from the IRS displaying your 9-digit individual tax identification number

Other Documents You May Choose to Provide

Form W-4S and Form CT-W4

Connecticut Paid Leave benefits are considered taxable income. If you would like your taxes to be withheld from any benefits you may receive, please complete the attached Form W-4S and the attached Form CT-W4 and return them to us. If we don't receive the forms back from you, no taxes will be withheld. To understand the impact of receiving paid leave benefits on your taxes, please contact your tax consultant.

Claim Payments
You were set up for direct deposit. If your claim for CT Paid Leave benefits is approved, payment will be deposited to your account. If you would like to change how you receive benefits, you can complete the attached Payment Election form or contact our Customer Care team at (877) 499-8606.

Third-Party Authorization
If you would like to authorize someone to have access to your case information and/or speak to us on your behalf, please complete the enclosed Third-Party Authorization form. If you do not want to authorize anyone, there is no need to fill out the form.

How to send us forms and information:

You have the following options on how you can send us forms and information that we need:

- To take a photo or scan and upload it in to your case, visit **https://ctpaidleave.org/** and register/login; or
- Fax to (888) 485-0973; or
- You can email it to us at **CTPFL@Aflac.com**; or
- Mail it to us at:

  Aflac CTPFML Administration
  PO Box 84077
  Columbus GA 31908-4077

Choose your communication preferences:

Visit https://ctpaidleave.org/ to register/login, click on the **Personal Info** tile-click on **Manage Your Account**, and then click on **Notifications**:

- Update your **Communication Preferences**, click the gear icon and follow the prompts to set your preferences.
- Update your **Text Messaging Preferences**, click on the gear icon and follow the prompts to set your preferences.

Looking for more information?

Getting helpful information during your time away from work is simple. Our portal allows you to check the status of your paid leave benefit case, upload documents and manage your communication preferences including text notification. Get started today by visiting https://ctpaidleave.org/ to register/login. Use Google Chrome to ensure you get the best experience.

Our Customer Care Advocates are available to answer any questions you may have. You can contact them Monday through Friday at (877) 499-8606 from 8:00 am to 8:00 pm EST.

Sincerely,

Aflac Connecticut Paid Leave Administration Team *

Enclosures:

Authorization for Release of Health-Related Information

Certification for Serious Health Condition
Employment Verification
Form W-4S
Form CT-W4
Payment Election
Third Party Authorization

** Claims administered by American Family Life Assurance Company of Columbus or its affiliates.*

Connecticut Paid Leave

Medical Authorization

Aflac CTPFML Administration
PO Box 84077
Columbus GA 31908-4077

Toll Free: (877) 499-8606
Fax: (888) 485-0973
Email: CTPFL@Aflac.com

Applicant Information (To be completed by the Applicant)

First Name: Jaime	Last Name: Perez	Case Number: 00353299
Phone number:	Last 4 Digits of SSN:	Date of Birth:
Address:	City, State:	Zip Code:

This authorization complies with the HIPAA Privacy Rule

I authorize my employer or agent acting on behalf of my employer, any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, clearinghouse, medical facility, or other health care provider ("Providers"), insurance company, or insurance support organization, to disclose the entire medical record, prescription drug history, and any other health or billing information, including any and all information regarding the diagnosis, treatment or care of any physical or mental condition ("Health Information") concerning me, to American Family Life Assurance Company (AFLAC), and its agents, employees, representatives, and reinsurers.

Health Information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Health Information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I am authorizing the Providers to disclose Health Information for the purpose of determining eligibility for benefits under the CT Paid Leave Program.

By my signature below, I acknowledge that any agreements made to restrict my Health Information do not apply to limit disclosures under this Authorization and I instruct my employer or agent acting on behalf of my employer, any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, clearinghouse, medical facility, or other health care provider, insurance company, or insurance support organization, to release and disclose my entire medical record without restriction.

This Authorization shall remain in force for the duration of the claim. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written notice to Aflac. I understand that a revocation is not effective to the extent that any of the Providers has already disclosed information in reliance on this Authorization. I understand that any Health Information that is disclosed pursuant to this Authorization may be re-disclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release my Health Information, Aflac may not be able to make any evaluation or process a claim for benefit payments.

I understand that I am entitled to receive a signed copy of this Authorization.

Important* *The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking you and your healthcare provider not to provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

Employee Signature	**Date**

CTPL-0013 (08-2021)

* *Claims administered by American Family Life Assurance Company of Columbus or its affiliates.*

Connecticut Paid Leave

Certification for Serious Health Condition

Aflac CTPFML Administration
PO Box 84077
Columbus GA 31908-4077

Toll Free: (877) 499-8606
Fax: (888) 485-0973
Email: CTPFL@Aflac.com

Applicant Information

First Name: Jaime	Last Name: Perez	Case Number: 00353299
Last 4 Digits of SSN:	Date of Birth:	
Address: 74 Meryl court	City: Groton	State: Connecticut / Zip Code: 06340
Cell Number:	Phone Number:	Work Number:

Employer Information

Employer Name:	Date of Hire:
Address:	
City:	State: / Zip Code:
Job Title:	Job Duties:

What is the Paid Leave for?

☐ My Own Serious Health Condition ☐ Pregnancy ☐ Organ/Bone Marrow Donation

Health Care Provider Information

Health Care Provider's Name:

Health Care Provider's Business Address:

City:	State:	Zip Code:

Type of Practice/Medical Specialty:

Certificate license number and state:

Telephone:	Fax:	Email:

Part A: Medical Information (To Be Completed By Health Care Provider)

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under Connecticut Paid Leave (CT PL).

Limit your response to the medical condition(s) for which the employee is seeking CT Paid Leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For CT PL purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

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Applicant First Name: Jaime	Applicant Last Name: Perez	Case Number: 00353299

Part A: Medical Information (continued)

1. State the approximate date the condition started or will start: ______________________

2. Provide your best estimate of how long the condition lasted or will last: ______________________

3. Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ Inpatient Care: The patient ☐ has been / ☐ is expected to be admitted for an overnight stay in a hospital, hospice or residential medical care facility on the following dates: ______________________

☐ Incapacity plus Treatment: *(e.g. outpatient surgery, broken leg)*

Due to the condition, the patient ☐ has been / ☐ is expected to be incapacitated for *more than* three consecutive, full calendar days from ____________ *(mm/dd/yyyy)* to ____________ *(mm/dd/yyyy).*

The patient (☐ was / ☐ will be) seen on the following date(s): ______________________

____

And, the condition ☐ has / ☐ has not also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication *(other than over-the-counter) or therapy requirement special equipment).*

☐ Pregnancy: The condition is pregnancy. Expected date of delivery: ____________ *(mm/dd/yyyy)*

☐ Chronic Conditions: *(e.g. asthma, migraine headaches)* It is medically necessary for the patient receive treatment from a healthcare provider for this condition at least 2 times per year. Please provide the dates of the last two appointments and the next scheduled appointment.

Last two appointments: ____________ *(mm/dd/yyyy)*, and ____________ *(mm/dd/yyyy)*

Next scheduled appointment: ____________ *(mm/dd/yyyy)*

☐ Permanent or Long Term Conditions: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ Conditions requiring Multiple Treatments: *(e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments. Please provide the frequency: ______________________

____

☐ Organ/Bone Marrow Donor: Due to this condition, the patient will require medical care on the following dates and will be out of work: ______________________

____

4. Briefly describe other appropriate medical facts related to the condition(s) for which the applicant seeks CT Paid Leave benefits that demonstrate the individual has a serious health condition as defined above.

____

____

____

____

____

Applicant First Name: Jaime	Applicant Last Name: Perez	Case Number: 00353299

Part B: Amount of Leave Needed (To be completed by Health Care Provider)

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" will not be sufficient to determine CT Paid Leave coverage.

1. Due to the condition, the patient needed/will need time off from work for **planned medical treatment**(s) (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)*. Please list the applicable dates for treatment: ______________________________

   ____

2. Due to the condition, the patient was/will be **referred to other health care provider(s)** and will need time off from work for evaluation or treatment.

   State the nature of such treatments *(e.g. cardiologist, physical therapy)*: ______________________________

   ____

   Provide your **best estimate** of the beginning date ____________ *(mm/dd/yyyy)*; and the end date ____________ *(mm/dd/yyyy)*.

   Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)* ______________________________

3. Due to the condition, it was/will be medically necessary for the employee to work a **reduced schedule**.

   Provide your **best estimate** of the reduced schedule the employee is able to work:

   From ____________ *(mm/dd/yyyy)* to ____________ *(mm/dd/yyyy)* the employee is able to work ____________ *(e.g. 5 hours/day, up to 25 hours a week)*.

4. Due to the condition, the patient was/will be **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

   Provide your **best estimate** of the beginning date ____________ *(mm/dd/yyyy)* and the end date ____________ *(mm/dd/yyyy)* for the period of incapacity.

5. Due to the condition, it was/will be medically necessary for the applicant to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

   Over the next 6 months, episodes of incapacity are estimated to occur ____________ times per ☐ day / ☐ week / ☐ month and are likely to last approximately ____________ ☐ hours / ☐ days per episode.

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Health Care Provider Signature & Credentials	Date

Connecticut Paid Leave

Employment Verification

Instructions to the employer: Please complete the following information and return to Aflac within **10 calendar days** of receipt of this form. You can send it by email CTPFL@Aflac.com or **fax to** (888) 485-0973 .

Section 1: Applicant's Leave Information *(to be completed by the Applicant or the Employer)*

First Name: Jaime	Last Name: Perez	Date of Birth:
Last 4 Digits of SSN:	Beginning Date of Leave:	End Date of Leave:
Leave Type: ☐ Continuous ☐ Intermittent ☐ Reduced schedule		Case Number: 00353299

Reason for Leave: ☐ Employee's own serious health condition ☐ Caregiver leave ☐ Bonding leave
☐ Military caregiver leave ☐ Qualifying exigency leave ☐ Family violence leave

Section 2: Employer Information *(to be completed by the Employer)*

Employer Name:

Address:

City:	State:	Zip Code:
Contact Name:	FEIN:	
Contact Phone Number:	Contact Email:	

If one of the following categories is applicable, check the appropriate box and return the form to Aflac without completing the remaining sections of the form:

☐ Federal Government ☐ Railroad ☐ Private Elementary or Secondary School ☐ Sovereign Nation
☐ Government of another state ☐ Non-contributing employee of a Municipality or a Board of Education
☐ Non-contributing employee of CT State Government

Section 3: Applicant's Income and Work Schedule *(to be completed by the Employer)*

Employee's Rate of Pay (e.g., $13/hour or $800/week):	Employee's Hire Date:	Date of employee's separation from employment (if applicable):

Please select the work days that the employee **typically** works

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

A "workweek" is the employee's usual or normal schedule (hours per week). If the employee has a standard workweek (e.g., 40 hours/week, or 24 hours/week) please provide that schedule:

If the employee's workweek varies from week to week, please state the hours worked in each of the 12 weeks prior to the receipt of this form or prior to the start of leave, whichever occurs first (including any overtime worked), **plus** any hours for which the employee took any paid time off:

Week 1:	Week 2:	Week 3:	Week 4:
Week 5:	Week 6:	Week 7:	Week 8:
Week 9:	Week 10:	Week 11:	Week 12:

Section 4: Scheduled Closures *(to be completed by the Employer)*

For the requested leave period, please provide the dates of any Company holidays or other scheduled closures or shutdowns during which the employee would not ordinarily be expected to work if not on leave:

CTPL-0006 (02-2022)

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Applicant's First Name: Jaime	Applicant's Last Name: Perez	Case Number: 00353299

Section 5: Other Potential Sources of Income *(to be completed by the Employer)*

Has the employee **applied** for Worker's Compensation benefits? ☐ Yes ☐ No

- If Yes, have the Worker's Compensation benefits been approved? ☐ Yes ☐ No
  - If Yes, please indicate the dates for which the employee is approved to receive Worker's Compensation Benefits: To: ______________________________ From: ________________________

"Income-replacement benefits" refers to employer-provided sources of income to the employee, including sick leave, vacation leave, paid time off, disability benefits, etc. **Please indicate which of the following applies to the employee (please check all that apply):**

☐ Employee will not receive any employer-provided income-replacement benefits while on leave.

☐ Employee will receive employer-provided income-replacement benefits equal to the employee's regular wages for the entire duration of the employee's leave.

☐ Employee will receive employer-provided income-replacement benefits that are equal to the employee's regular wages for a portion of the employee's leave.

Please indicate the date the employee will stop receiving such income-replacement benefits: _______________

☐ Employee will receive employer-provided income-replacement benefits that are less than the employee's regular wages for some or all of the employee's leave.

Please indicate if the employer-provided income-replacement benefits are:
☐ **primary** - the benefit payment duration and amount will be the same whether or not CTPL benefits are payable
☐ **secondary** - the benefit payment will be delayed or reduced if CTPL benefits are payable

If the employer-provided income-replacement benefits are **primary**, what percentage of the employee's wages will be paid and for how long? Percentage: _________ Duration: ___________________________

If percentage will change over time, please indicate separate percentages on each line below as applicable:

Percentage: ________________ Duration: ____________________________________

Percentage: ________________ Duration: ____________________________________

If the income-replacement benefits are secondary, CT Paid Leave delegates to the employer the responsibility for complying with the statutory requirement that the sum of the CT Paid Leave benefits plus employer-provided benefits does not exceed 100% of the employee's regular wages.

Section 6: Leaves Requiring Additional Employer Approval *(to be completed by the Employer)*

Complete only if Intermittent or Reduced Schedule Bonding Leave is requested by the employee:
Have you approved your employee to take intermittent leave or reduced schedule leave for the purpose of bonding with a newborn or newly adopted child or newly placed foster child? ☐Yes ☐ No

If **Yes**, please describe the timing, frequency and duration of intermittent leave or change in schedule *(e.g., leave taken 2 days/month, schedule reduced by 15%)*: ____

Complete only if Qualifying Exigency Leave for an "other approved reason" is requested by the employee:
Have you approved your employee to take qualifying exigency leave for a reason other than leave to address short-notice deployment, military events and related activities, emergency childcare or parental care, financial and legal arrangements, counseling, covered servicemember's rest and recuperation, post-deployment activities? ☐ Yes ☐ No

If **Yes**, please describe the timing, frequency and duration of such qualifying exigency leave, *(e.g., leave taken 2 days/month, schedule reduced by 15%)*: ____

Section 7: Employer Declaration and Signature

Under penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein is true, correct, and complete. Any false statements or other failure to provide truthful, accurate, and complete information may result in monetary and other penalties as well as the possibility of criminal prosecution.

Signature	**Date**
Printed Name	**Title**

CTPL-0006 (02-2022)

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Form **W-4S**

Department of the Treasury
Internal Revenue Service

Request for Federal Income Tax Withholding From Sick Pay

► **Give this form to the third-party payer of your sick pay.**
► **Go to *www.irs.gov/FormW4S* for the latest information.**

OMB No. 1545-0074

2022

Your first name and middle initial	Last name	**Your social security number**

Home address (number and street or rural route)

City or town, state, and ZIP code

Claim or identification number (if any)	
I request federal income tax withholding from my sick pay payments. I want the following amount to be withheld from each payment. (See **Worksheet** below.)	$

Employee's signature ► Date ►

Separate here and give the top part of this form to the payer. Keep the lower part for your records.

Worksheet (Keep for your records. Do not send to the IRS.)

1	Enter amount of adjusted gross income that you expect in 2022	**1**	
2	If you plan to itemize deductions on Schedule A (Form 1040), enter the estimated total of your deductions. See Pub. 505 for details. If you don't plan to itemize deductions, enter the standard deduction. (See the instructions on page 2 for the standard deduction amount, including additional standard deductions for age and blindness.) **Note:** There is no deduction for personal exemptions for 2022	**2**	
3	Subtract line 2 from line 1	**3**	
4	Tax. Figure your tax on line 3 by using the **2022** Tax Rate Schedule X, Y-1, Y-2, or Z on page 2. **Do not** use any tax tables, worksheets, or schedules in the 2021 Instructions for Form 1040	**4**	
5	Credits (child tax and higher education credits, credit for child and dependent care expenses, etc.) . .	**5**	
6	Subtract line 5 from line 4	**6**	
7	Estimated federal income tax withheld or to be withheld from other sources (including amounts withheld due to a prior Form W-4S) during 2022 or paid or to be paid with 2022 estimated tax payments . . .	**7**	
8	Subtract line 7 from line 6	**8**	
9	Enter the number of sick pay payments you expect to receive this year to which this Form W-4S will apply	**9**	
10	Divide line 8 by line 9. Round to the nearest dollar. This is the amount that should be withheld from each sick pay payment. Be sure it meets the requirements for the amount that should be withheld, as explained under *Amount to be withheld* below. If it does, enter this amount on Form W-4S above . .	**10**	

General Instructions

Purpose of form. Give this form to the third-party payer of your sick pay, such as an insurance company, if you want federal income tax withheld from the payments. You aren't required to have federal income tax withheld from sick pay paid by a third party. However, if you choose to request such withholding, Internal Revenue Code sections 3402(o) and 6109 and their regulations require you to provide the information requested on this form. Don't use this form if your employer (or its agent) makes the payments because employers are already required to withhold federal income tax from sick pay.

Note: If you receive sick pay under a collective bargaining agreement, see your union representative or employer.

Definition. Sick pay is a payment that you receive:

- Under a plan to which your employer is a party, and
- In place of wages for any period when you're temporarily absent from work because of your sickness or injury.

Amount to be withheld. Enter on this form the amount that you want withheld from each payment. The amount that you enter:

- Must be in whole dollars (for example, $35, not $34.50).
- Must be at least $4 per day, $20 per week, or $88 per month based on your payroll period.
- Must not reduce the net amount of each sick pay payment that you receive to less than $10.

For payments larger or smaller than a regular full payment of sick pay, the amount withheld will be in the same proportion as your regular withholding from sick pay. For example, if your regular full payment of $100 a week normally has $25 (25%) withheld, then $20 (25%) will be withheld from a partial payment of $80.

Caution: You may be subject to a penalty if your tax payments during the year aren't at least 90% of the tax shown on your tax return. For exceptions and details, see Pub. 505, Tax Withholding and Estimated Tax. You may pay tax during the year through withholding or estimated tax payments or both. To avoid a penalty, make sure that you have enough tax withheld or make estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. You may estimate your federal income tax liability by using the worksheet above.

Sign this form. Form W-4S **is not** valid unless you sign it.

Statement of income tax withheld. After the end of the year, you'll receive a Form W-2, Wage and Tax Statement, reporting the taxable sick pay paid and federal income tax withheld during the year. These amounts are reported to the IRS.

(continued on back)

Changing your withholding. Form W-4S remains in effect until you change or revoke it. You may do this by giving a new Form W-4S or a written notice to the payer of your sick pay. To revoke your previous Form W-4S, complete a new Form W-4S and write "Revoked" in the money amount box, sign it, and give it to the payer.

Specific Instructions for Worksheet

You may use the worksheet on page 1 to estimate the amount of federal income tax that you want withheld from each sick pay payment. Use your tax return for last year and the worksheet as a basis for estimating your tax, tax credits, and withholding for this year.

You may not want to use Form W-4S if you already have your total tax covered by estimated tax payments or other withholding.

If you expect to file a joint return, be sure to include the income, deductions, credits, and payments of both yourself and your spouse in figuring the amount you want withheld.

Caution: If any of the amounts on the worksheet change after you give Form W-4S to the payer, you should use a new Form W-4S to request a change in the amount withheld.

Line 2—Deductions

Itemized deductions. Itemized deductions include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your adjusted gross income. See Pub. 505 for details.

Standard deduction. For 2022, the standard deduction amounts are:

Filing Status	Standard Deduction
Married filing jointly or qualifying widow(er)	$25,900*
Head of household	$19,400*
Single or Married filing separately	$12,950*

* If you're age 65 or older or blind, add to the standard deduction amount the additional amount that applies to you as shown in the next paragraph. If you can be claimed as a dependent on another person's return, see *Limited standard deduction for dependents,* later.

Additional standard deduction for the elderly or blind. An additional standard deduction of $1,400 is allowed for a married individual (filing jointly or separately) or a qualifying widow(er) who is 65 or older or blind, $2,800 if 65 or older **and** blind. If both spouses are 65 or older or blind, an additional $2,800 is allowed on a joint return. If both spouses are 65 or older **and** blind, an additional $5,600 is allowed on a joint return. Additional standard deductions are also allowed on your separate return for your spouse who is 65 or older and/or blind if your spouse has no gross income and can't be claimed as a dependent by another taxpayer. An additional $1,750 is allowed for an unmarried individual (single or head of household) who is 65 or older or blind, $3,500 if 65 or older **and** blind. See the 2022 Estimated Tax Worksheet—Line 2 Standard Deduction Worksheet in Pub. 505.

Limited standard deduction for dependents. If you are a dependent of another person, your standard deduction is the greater of (a) $1,150 or (b) your earned income plus $400 (up to the regular standard deduction for your filing status). If you're 65 or older or blind, see Pub. 505 for additional amounts that you may claim.

Certain individuals not eligible for standard deduction. For the following individuals, the standard deduction is zero.

- A married individual filing a separate return if either spouse itemizes deductions.
- A nonresident alien individual. For exceptions, see Pub. 519, U.S. Tax Guide for Aliens.
- An individual filing a return for a period of less than 12 months because of a change in his or her annual accounting period.

Line 5—Credits

Include on this line any tax credits that you're entitled to claim, such as the child tax credit and credit for other dependents, higher education credits, credit for child and dependent care expenses, earned income credit, or credit for the elderly or the disabled. See the Tax Credits table in Pub. 505 for more information.

Line 7—Tax Withholding and Estimated Tax

Enter the federal income tax that you expect will be withheld this year on income other than sick pay and any payments made or to be made with 2022 estimated tax payments. Include any federal income tax already withheld or to be withheld from wages and pensions.

2022 Tax Rate Schedules

Schedule X—Single

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$10,275	**$0 + 10%**	**$0**
10,275	41,775	**1,027.50 + 12%**	**10,275**
41,775	89,075	**4,807.50 + 22%**	**41,775**
89,075	170,050	**15,213.50 + 24%**	**89,075**
170,050	215,950	**34,647.50 + 32%**	**170,050**
215,950	539,900	**49,335.50 + 35%**	**215,950**
539,900	and greater	**162,718 + 37%**	**539,900**

Schedule Z—Head of household

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$14,650	**$0 + 10%**	**$0**
14,650	55,900	**1,465 + 12%**	**14,650**
55,900	89,050	**6,415 + 22%**	**55,900**
89,050	170,050	**13,708 + 24%**	**89,050**
170,050	215,950	**33,148 + 32%**	**170,050**
215,950	539,900	**47,836 + 35%**	**215,950**
539,900	and greater	**161,218.50 + 37%**	**539,900**

Schedule Y-1—Married filing jointly or Qualifying widow(er)

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$20,550	**$0 + 10%**	**$0**
20,550	83,550	**2,055 + 12%**	**20,550**
83,550	178,150	**9,615 + 22%**	**83,550**
178,150	340,100	**30,427 + 24%**	**178,150**
340,100	431,900	**69,295 + 32%**	**340,100**
431,900	647,850	**98,671 + 35%**	**431,900**
647,850	and greater	**174,253.50 + 37%**	**647,850**

Schedule Y-2—Married filing separately

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$10,275	**$0 + 10%**	**$0**
10,275	41,775	**1,027.50 + 12%**	**10,275**
41,775	89,075	**4,807.50 + 22%**	**41,775**
89,075	170,050	**15,213.50 + 24%**	**89,075**
170,050	215,950	**34,647.50 + 32%**	**170,050**
215,950	323,925	**49,335.50 + 35%**	**215,950**
323,925	and greater	**87,126.75 + 37%**	**323,925**

Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Department of Revenue Services
State of Connecticut
(Rev. 12/21)

Form CT-W4
Employee's Withholding Certificate

Complete this form in blue or black ink only.

Effective January 1, 2022

Employee Instructions

- Read the instructions on Page 2 before completing this form.
- Select the filing status you expect to report on your Connecticut income tax return. See instructions.
- Choose the statement that best describes your gross income.
- Enter the *Withholding Code* on Line 1 below.

Married Filing Jointly	Withholding Code
Our expected combined annual gross income is **less** than or equal to $24,000 or I am claiming exemption under the Military Spouses Residency Relief Act (MSRRA)* and no withholding is necessary.	E
My spouse **is** employed and our expected combined annual gross income is **greater** than $24,000 and less than or equal to $100,500. See *Certain Married Individuals*, Page 2.	A
My spouse **is not** employed and our expected combined annual gross income is **greater** than $24,000.	C
My spouse **is** employed and our expected combined annual gross income is **greater** than $100,500.	D
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D

Qualifying Widow(er)	Withholding Code
My expected annual gross income is **less** than or equal to $24,000 or I am claiming exemption under the MSRRA* and no withholding is necessary.	E
My expected annual gross income is **greater** than $24,000.	C
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D

Married Filing Separately	Withholding Code
My expected annual gross income is **less** than or equal to $12,000 or I am claiming exemption under the MSRRA* and no withholding is necessary.	E
My expected annual gross income is **greater** than $12,000.	A
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D

Single	Withholding Code
My expected annual gross income is **less** than or equal to $15,000 and no withholding is necessary.	E
My expected annual gross income is **greater** than $15,000.	F
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D

Head of Household	Withholding Code
My expected annual gross income is **less** than or equal to $19,000 and no withholding is necessary.	E
My expected annual gross income is **greater** than $19,000.	B
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D

* If you are claiming the Military Spouses Residency Relief Act (MSRRA) exemption, see instructions on Page 2.

Employees: See *Employee General Instructions* on Page 2. Sign and return Form CT-W4 to your employer. Keep a copy for your records.

1. Withholding Code: Enter *Withholding Code* letter chosen from above. .... 1. ____________
2. Additional withholding amount per pay period: If any, see instructions. .... 2. $____________
3. Reduced withholding amount per pay period: If any, see instructions. .... 3. $____________

☐ Check if you are claiming the MSRRA exemption and enter state of legal residence/domicile: ____________

First name	MI	Last name	Social Security Number
Home address (number and street, apartment number, suite number, PO Box)			
City/town	State	ZIP code	

Declaration: I declare under penalty of law that I have examined this certificate and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for reporting false information is a fine of not more than $5,000, imprisonment for not more than five years, or both.

Employee's signature	Date

Employers: See *Employer Instructions,* on Page 2.

Is this a new or rehired employee? ☐ No ☐ Yes Enter date hired: ____________ mm/dd/yyyy

Employer's business name			Federal Employer Identification Number
Employer's business address			
City/town	State	ZIP code	
Contact person			Telephone number – –

Visit us at **portal.ct.gov/DRS** for more information.

Form CT-W4 Instructions

Employee General Instructions

Form CT-W4, *Employee's Withholding Certificate,* provides your employer with the necessary information to withhold the correct amount of Connecticut income tax from your wages to ensure that you will not be underwithheld or overwithheld.

You are required to pay Connecticut income tax as income is earned or received during the year. You should complete a new Form CT-W4 at least once a year or if your tax situation changes.

If your circumstances change, such as you receive a bonus or your filing status changes, you must furnish your employer with a new Form CT-W4 within ten days of the change.

Gross Income

For Form CT-W4 purposes, ***gross income*** means all income from all sources, whether received in the form of money, goods, property, or services, not exempt from federal income tax, and includes any additions to income from *Schedule 1* of **Form CT-1040**, *Connecticut Resident Income Tax Return* or **Form CT-1040NR/PY**, *Connecticut Nonresident and Part-Year Resident Income Tax Return*.

Filing Status

Generally, the filing status you expect to report on your Connecticut income tax return is the same as the filing status you expect to report on your federal income tax return. However, special rules apply to married individuals who file a joint federal return but have a different residency status. Nonresidents and part-year residents should see the instructions to Form CT-1040NR/PY.

Check Your Withholding

You may be underwithheld if any of the following apply:

- You have more than one job;
- You qualify under *Certain Married Individuals*; **or**
- You have substantial nonwage income.

If you are underwithheld, you should consider adjusting your withholding or making estimated payments using **Form CT-1040ES**, *Estimated Connecticut Income Tax Payment Coupon for Individuals*. You may also select *Withholding Code* "D" to elect the highest level of withholding.

If you owe $1,000 or more, after subtracting from your Connecticut income tax the amount withheld from your income for the prior taxable year, and any PE Tax Credit, you may be subject to interest on the underpayment at the rate of 1% per month or fraction of a month.

To help determine if your withholding is correct, see **Informational Publication 2022(7)**, *Is My Connecticut Withholding Correct?*

Certain Married Individuals

If you are a married individual filing jointly and you and your spouse both select *Withholding Code* "A," you may have too much or too little Connecticut income tax withheld from your pay. This is because the phase-out of the personal exemption and credit is based on your combined incomes. The withholding tables cannot reflect your exact withholding requirement without considering the income of your spouse.

To minimize this problem, and determine if you need to adjust your withholding using Line 2 or Line 3, see IP 2022(7).

Nonresident Employees Working Partly Within and Partly Outside of Connecticut

If you work partly within and partly outside of Connecticut for the same employer, you should also complete **Form CT-W4NA**, *Employee's Withholding or Exemption Certificate - Nonresident Apportionment*, and provide it to your employer. The information on Form CT-W4NA and Form CT-W4 will help your employer determine how much to withhold from your wages for services performed within Connecticut. Residents of states with a "convenience of the employer" test will be subject to similar rules for work performed for a Connecticut employer. Any nonresident who expects to have no Connecticut income tax liability should choose *Withholding Code* "E."

Armed Forces Personnel and Veterans

If you are a Connecticut resident, your armed forces pay is subject to Connecticut income tax withholding unless you qualify as a nonresident for Connecticut income tax purposes. If you qualify as a nonresident, you may request that no Connecticut income tax be withheld from your armed forces pay by entering *Withholding Code* "E" on Line 1.

Military Spouses Residency Relief Act (MSRRA)

If you are claiming an exemption from Connecticut income tax under the MSRRA, you must provide your employer with a copy of your military spouse's Leave and Earnings Statement (LES) and a copy of your military dependent ID card.

See **Informational Publication 2019(5)**, *Connecticut Income Tax Information for Armed Forces Personnel and Veterans*.

Employer Instructions

For any employee who does not complete Form CT-W4, you are required to withhold at the highest marginal rate of 6.99% without allowance for exemption. You are required to keep Form CT-W4 in your files for each employee. See **Informational Publication 2022(1)**, *Connecticut Employer's Tax Guide, Circular CT*, for complete instructions.

Report Certain Employees Claiming Exemption From Withholding to DRS

Employers are required to file copies of Form CT-W4 with DRS for certain employees claiming "E" (no withholding is necessary). See IP 2022(1). Mail copies of Forms CT-W4 meeting the conditions listed in IP 2022(1) under *Reporting Certain Employees* to*:*

Department of Revenue Services
PO Box 2931
Hartford CT 06104-2931

Report New and Rehired Employees to the Department of Labor

New employees are workers not previously employed by your business, or workers rehired after having been separated from your business for more than sixty consecutive days.

Employers with offices in Connecticut or transacting business in Connecticut are required to report new hires to the Department of Labor (DOL) within 20 days of the date of hire.

New hires can be reported by:

- Using the Connecticut New Hire Reporting website at **www.ctnewhires.com**;
- Faxing copies of completed Forms CT-W4 to **800-816-1108**; **or**
- Mailing copies of completed Forms CT-W4 to:

Connecticut Department of Labor
Office of Research, CT-W4
200 Folly Brook Blvd
Wethersfield CT 06109

For more information on DOL requirements or for alternative reporting options, visit the DOL website at **www.ctdol.state.ct.us** or call DOL at 860-263-6310.

For Further Information

Visit the DRS website at **portal.ct.gov/DRS**.

Call DRS Monday through Friday, 8:30 a.m. to 4:30 p.m. at:

- **800-382-9463** (Connecticut calls outside the Greater Hartford calling area only); **or**
- **860-297-5962** (from anywhere).

TTY, TDD, and Text Telephone users **only** may transmit inquiries anytime by calling 860-297-4911. Taxpayers may also call 711 for relay services. A taxpayer must tell the 711 operator the number he or she wishes to call. The relay operator will dial it and then communicate using a TTY with the taxpayer.

Connecticut Paid Leave

Payment Election

Aflac CTPFML Administration
PO Box 84077
Columbus GA 31908-4077

Toll Free: (877) 499-8606
Fax: (888) 485-0973
Email: CTPFL@Aflac.com

Applicant Information

First Name: Jaime	Last Name: Perez	Date of Birth:
Phone number:	Last 4 Digits of SSN:	Case Number: 00353299
Address: 74 Meryl court	City, State: Groton, Connecticut	Zip Code: 06340

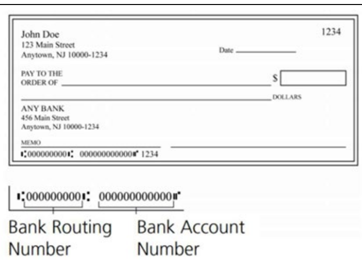
Visa Debit Card

☐ Please issue a Visa® Debit Card for my CT Paid Leave benefits. I understand that I will receive a welcome letter from Money Network® with my Visa Debit Card. If I am approved for CT Paid Leave benefits, payments will be deposited to the debit card for use.

Banking Information

☐ Please update my information with the below banking information. If I am approved for CT Paid Leave benefits, payments will be deposited to the account listed below.

Name of Bank:		
Address:		
City:	State:	Zip Code:
Bank Phone Number:	Country:	



Effective date: ____________________

Bank Account Type: ☐ Checking ☐ Savings

Bank Routing Number: ____________________

Bank Account Number: ____________________

Note: A voided check or deposit slip is required to process your request. If a voided check or deposit slip is not included, we will not be able to process your request for direct deposit.

Applicant Signature	**Date**

Important Payment and Tax Notices for Non-U.S. Resident Payees: Aflac makes payments under the policy only to the payee(s) contractually entitled to such payments. When the payee resides outside the United States, payments will only be made by wire transfer to an account in the name of the payee at a bank located in the country where the payee actually lives or has a permanent residence. Under no circumstances will cash or cash equivalent payments be made under the policy.

Aflac policies are designed to be sold to and serviced for persons and entities who reside in the U.S. Aflac does not provide any taxadvice. If you live outside of the U.S., you should obtain independent legal or tax advice concerning the tax consequences, relativeto the policy, of residing outside the U.S. when the policy is issued or when changing your country of residence after the policy has been issued. Aflac does not make any representations regarding any tax consequences that may arise in respect of (1) the policy and/or (2) any payments made under the policy, as a result of you residing outside the U.S. at the time of issue or changing your country of residence after the policy has been issued.

CTPL-0011 (11-2021)

** Claims administered by American Family Life Assurance Company of Columbus or its affiliates.*

Connecticut Paid Leave

Third Party Authorization To Release Form

Aflac

Aflac CTPFML Administration
PO Box 84077
Columbus GA 31908-4077

Toll Free: (877) 499-8606
Fax: (888) 485-0973
Email: CTPFL@Aflac.com

Third Party Authorization to Release Personal Health Claim and Benefit Information

First Name: Jaime	Last Name: Perez	Case Number: 00353299	
Phone Number:	Last 4 Digits of SSN:	Date of Birth:	
Street Address: 74 Meryl court	City: Groton	State: Connecticut	Zip Code: 06340

I request and authorize American Family Assurance Company of Columbus (Aflac) to release my personal health, claim and benefit information to the following designated individual(s) or entities:

Name:	Telephone:	Relationship:	
Street Address:	City:	State:	Zip Code:
Name:	Telephone:	Relationship:	
Street Address:	City:	State:	Zip Code:

Information to be release: I allow Aflac to share information with the person(s) listed above. I understand that the company needs my written consent to release any sensitive information. Sensitive information includes testing, diagnosis, procedures, and or treatment of Alcohol and Chemical Dependency, Reproductive Health, Sexually Transmitted diseases (STD) including HIV/AIDS, genetic Information, or Psychiatric and Mental Illness.

This request and authorization applies to:

☐ Discuss claim and benefit information including sensitive information: ______________________

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Unless otherwise revoked, this Optional Authorization is to remain in effect for a period of 12 months.

For any period greater than 12 months, a new Optional Authorization must be completed and submitted at the end of initial 12-month period.

I understand that I may revoke this Optional Authorization at any time and that such revocation will take effect only upon receipt of written notice by Aflac.

I understand that any such revocation shall not apply to any disclosure or re-disclosure of information made in reliance on my initial Authorization.

I understand that the information provided to the designated individual(s) is subject to re-disclosure and might not be protected by certain state and federal regulations governing the privacy of health and financial information.

I may request a copy of this authorization and a copy shall be as valid as the original.

Applicant Signature	Date

CTPL-0014 (10-2021)

** Claims administered by American Family Life Assurance Company of Columbus or its affiliates.*